PREMIER
PRIMARY CARE MEDICINE

# REGISTRATION FORM

## PATIENT INFORMATION

Which office would you prefer to make your primary location? ❑ East Cobb: 3775 Roswell Rd. STE 375, Marietta, GA 30062
❑ Smyrna: 3903 S. Cobb Dr. SE, STE 200, Smyrna, GA 30080

Date: _____ Name: _____ Date of birth: _____ Sex: ❑ M / ❑ F
(FIRST M.I. LAST)

Social Security # _____-_____-_____ Cell Phone: _____ Home Phone: _____

Work/Daytime Phone: _____ Email: _____

Home Address: _____
(STREET CITY STATE ZIP)

Race: ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American
❑ Native Hawaiian/Other Pacific Islander ❑ White ❑ Unknown

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown **Primary Language:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

**IF PATIENT IS A MINOR PLEASE PROVIDE FINANCIALLY RESPONSIBLE PARTY INFORMATION BELOW:**

Name of financially responsible party: _____ Social Security # _____-_____- _____
(FIRST M.I. LAST)

Date of birth: _____ Relationship to patient: ❑ Parent ❑ Legal Guardian ❑ Other _____

Address (if different from patient): _____
(STREET CITY STATE ZIP)

Cell Phone: _____ Home Phone: _____ Work Phone: _____

## INSURANCE INFORMATION

Insurance Company: _____ ID # _____ Co-pay amount: $ _____

Type: ❑ HMO ❑ POS ❑ PPO ❑ Medicare ❑ Other _____

Insurance Claims Address: _____
*(usually on back of insurance card)* (STREET CITY STATE ZIP)

Name of policy holder: _____ Policy holder's Social Security # _____-_____- _____
(FIRST M.I. LAST)

D.O.B. of policy holder: _____ Relationship to policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Address of policy holder (if different from patient): _____
(STREET CITY STATE ZIP)

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Policy Holder's Employer: _____ Occupation: _____

Secondary Insurance Company (If applicable):

## EMERGENCY CONTACT

Emergency Contact Name: _____ Relationship: _____

Primary Phone: _____ ❑ Cell ❑ Home ❑ Work

Secondary Phone: _____ ❑ Cell ❑ Home ❑ Work Other info: _____

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# PATIENT AGREEMENT & CONSENT

**1. Financial Agreement**

I hereby assume full responsibility for ail charges incurred for professional services rendered by providers/physicians, unless the services are deemed "paid in full" as a result of contractual agreement between Premier Primary Care Medicine office and my insurer. There may be a $35 No Show fee charged for appointments not cancelled within 24 hours. If you have paperwork to be filled out, a charge of $25 per page for the first 2 pages will apply and $80 for 3+ pages will apply. The charges will be due up-front prior to being seen by the provider. If you do not have insurance, payment will be collected prior to being seen by the provider. If you have additional balance afterwards then it will be collected after the visit. If your balance is less than the final amount, then you will be refunded the difference.

**2. Authorization for release of information**

I hereby authorize Premier Primary Care Medicine to release any medical, psychiatric, infectious disease (including AIDS confidential information), drugs and/or alcohol related information to my referring provider/physician or any insurance company with whom I have medical benefits for the purpose of filing a medical claim. I acknowledge that this information is valid until such time as all my medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date except to the extent that action has been taken in reliance hereon.

**3. Group & Individual Insurance, assignment of benefits**

I authorize my health insurance benefit to pay directly to Premier Primary Care Medicine, the surgical and/or medical benefits, if any, otherwise payable to me for their services as described on attached claim but not to exceed the charges for those services. I understand I am financially responsible to Premier Primary Care Medicine for charges not covered by this agreement.

**4. Medicare claim authorization and payment request**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

**5. Consent of Treatment**

I authorize request Premier Primary Care Medicine to provide medical examinations, treatment, and/or diagnostic procedures, (including: venipuncture, urinalysis, glucose testing, oximetry, hemoglobin testing, injections) which now or during the course of my care as a patient are advisable. The frequency and type of treatments/ procedures will be decided between the provider/ physician and myself. I understand that the purpose of these treatments/ procedures will be explained to me and be subject to my verbal agreement. I understand that there is an expectation that I will benefit from these treatments/procedures, but there is no guarantee that this will occur.

**6. Prescription Drug History Consent**

In order to give you the highest quality of medical care, we need accurate information regarding your prescription medications. Therefore, I grant Premier Primary Care Medicine permission to view my prescription history from my current or previous pharmacies.

**7. Notice of Physician Assistant's Services**

The physicians of this office employ the service of Physician's Assistants who are licensed in the State of Georgia to treat patients, order medications, and order other diagnostic testing under the supervision of the doctors of Premier Primary Care Medicine. This waiver gives you permission to see the Physician's Assistant unless otherwise specified at the time you make your appointment. We will honor your request for the practitioner of your choice, unless in verifiable emergencies.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE

_____

RELATIONSHIP TO PATIENT (IF NOT PATIENT)

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# PATIENT CONFIDENTIALITY & HIPAA ACKNOWLEDGEMENT

Patient Name: _____ Date of birth: _____
FIRST M.I. LAST

Patient confidentiality is a top priority at Premier Primary Care Medicine. Therefore, it is important that you provide us with the following information to ensure there is no violation of your privacy.

In the event that I am unable to be reached, Premier Primary Care Medicine may leave test results or other pertinent information with the following people:

| Name | Relationship | Phone | |
|---|---|---|---|
| _____ FIRST NAME _____ LAST NAME | _____ | _____ | ❑ Cell ❑ Home ❑ Work ❑ Other |
| _____ FIRST NAME _____ LAST NAME | _____ | _____ | ❑ Cell ❑ Home ❑ Work ❑ Other |
| _____ FIRST NAME _____ LAST NAME | _____ | _____ | ❑ Cell ❑ Home ❑ Work ❑ Other |
| _____ FIRST NAME _____ LAST NAME | _____ | _____ | ❑ Cell ❑ Home ❑ Work ❑ Other |

**MESSAGES**
May leave messages on voicemail/answering machine at: (check all that apply) ❑ home ❑ cell ❑ work phone

Other (Describe) _____

(Initials) _____ In the event I am unable to be reached, Premier Primary Care Medicine may **NOT** leave tests results or any other information with anyone but myself or the person listed above.

I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff of Premier Primary Care Medicine.

## Acknowledgment of Receipt of HIPAA Notice of Patient Privacy Practices

By signing this Written Acknowledgment of receipt of Premier Primary Care Medicine Notice of Patient Privacy Practices ("Acknowledgment"), I hereby expressly acknowledge my receipt of Premier Primary Care Medicine Notice of Patient Privacy Practices.

_____ _____
PATIENT OR LEGAL REPRESENTATIVE SIGNATURE DATE

_____
PATIENT OR LEGAL REPRESENTATIVE PRINTED NAME

**DO NOT WRITE HERE - FOR OFFICE STAFF USE**

❑ Acknowledgment NOT obtained because:

❑ Patient or Legal Representative declined Notice of Patient Privacy Practices

❑ Other (Briefly describe) _____

_____ _____
SIGNATURE OF EMPLOYEE DATE

_____
PRINTED NAME OF EMPLOYEE

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EAST COBB LOCATION
3775 Roswell Rd. • Suite 375
Marietta, GA 30062

PREMIER
PRIMARY CARE MEDICINE

SMYRNA LOCATION
3903 S. Cobb Dr. • Suite 200
Smyrna, GA 30080

770-435-3214 (TEL) • 770-437-6911 (FAX) • WWW.PREMIERPCMED.COM

# Authorization for Release of Medical Information

(Fill this page out if you would like for us to receive your previous medical records)

Date: _____ Patient Name: _____ Date of birth: _____
FIRST M.I. LAST

Home Phone: _____ Daytime Phone: _____

Home Address: _____
STREET CITY STATE ZIP

I authorize Premier Primary Care Medicine to:

☐ obtain information from:
☐ release information to:

Name of provider/facility: _____ Phone: _____

Address: _____
STREET CITY STATE ZIP

Fax number: _____

Specific description of information to be released:

❑ Complete Medical Records ❑ Progress Notes ❑ Labs Reports ❑ Radiology/Xray Reports

I authorize the release of records that my include diagnosis and treatment of HIV, alcohol & drug usage and/or mental health records). I understand that I may cancel this authorization at any time by submitting a written request to Premier Primary Care Medicine except where a disclosure has already been made in reliance on my prior authorization. If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be disclosed.

_____ _____
SIGNATURE OF PATIENT (OR LEGAL GUARDIAN) DATE

_____
RELATIONSHIP TO PATIENT (IF NOT PATIENT)

**Releasing provider or facility: Please return this form to**

**Premier Primary Care Medicine**
**3903 S. Cobb Dr., Suite 200 • Smyrna, GA 30080**

**or fax to (770) 437-6911**

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# MY RESPONSIBILITIES

To ensure that no billing issues occur, we need to inform you that it is **your responsibility** to check with your insurance company regarding the answers to the following questions:

1) Is Dr. David Kim considered **in-network** for my insurance plan?
    a. If you have a **secondary** or **supplemental** insurance please call your secondary insurance and check the in-network status as well.
    b. Also check and make sure your insurance is in **active status** and not inactive status.
2) Are **Annual Physicals** covered by my insurance? Are regular doctor visits (**Office Visits**) covered by my insurance? You need to inquire your insurance about these benefits.
    a. Note that some insurance companies will not allow Annual Physicals to be scheduled **until 365 days have lapsed** since your last Annual Physical. Other insurance companies will allow Annual Physicals as long as it's a new calendar year. Please call your insurance company to find out your policy.
    b. Note that **Medicare** patients have a **deductible** at the beginning of each year (amount is typically less than $200). This amount **may or may not be covered** by Medicare Supplement/Secondary insurance companies. If it is not covered, it is the patient's responsibility to pay the deductible amount.
3) Are **labs and radiology studies** (x-rays, ultrasounds, etc.) covered by my plan?
4) Are cosmetic and elective procedures covered by my plan?
5) What is my portion of the bill? Typically, the patient's portion of the bill falls into 3 categories: **deductible**, **copay**, and **co-insurance**. You need to know what your insurance policy's amount is on each of these areas.
    a. The **Deductible** is the amount per year that the patient has to pay before the insurance will begin paying. Most insurance companies have exceptions to the deductible, such as the annual physical visit which is not assigned to the deductible. You need to familiarize yourself with these rules.
    b. The **Copay** is the fixed amount of dollars that the patient is responsible for and is collected at the beginning of the office visit. Most insurance companies do not have a copay for Annual Physicals, but you should check your policy to be sure of this.
    c. The **Co-insurance** is the patient's responsibility but it's not a fixed amount but rather, a percentage of the final bill. Because the insurance has to process the claim and determine the final bill amount, we cannot collect this amount when you are at the visit. The Co-insurance will be billed to you after your insurance processes the claim (typically 1-2 months after the visit or procedure).

I understand that ultimately, it is my responsibility to know my insurance benefits and how they apply to me. I understand that I may contact my insurance company to inquire about my benefits by calling the customer service number on the back of my insurance card.

Printed Name: _____ Date: _____

Signature: _____

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# Medication Policy

The physicians and providers at Premier Primary Care Medicine do no prescribe pain medications that are considered controlled by the state of Georgia (such as hydrocodone, Tramadol, oxycodone, etc.). We also do not write for muscle relaxers (such as Soma [carisoprodol], Flexeril [cyclobenzaprine], Zanaflex [Tizanadine], Robaxin [methocarbamol], etc.). If you need such medications to treat your pain we will be happy to refer you to a pain management specialist. We also do not prescribe benzodiazepines for anxiety (such as Xanax, Ativan, etc.), as well as medications to treat ADD/ADHD (such as Ritalin, Adderall, etc.) and narcolepsy (such as Provigil, etc.). If you need these medications we will refer you to a specialist who can manage these medications for you.

I understand the above policies and agree to abide by them.

Printed Name: _____ Date: _____

Signature: _____

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Patient Name: _____ Date: _____

# NEW PATIENT INTAKE

*Welcome to Premier Primary Care Medicine! Please take this time to answer some questions about your health and medical history (front & back pages) to help us get to know you.*

PRIOR AND CURRENT MEDICAL ISSUES:

PAST SURGERIES/PROCEDURES AND YEAR:

FAMILY MEDICAL HISTORY: *First-degree relatives only.*

MEDICATIONS—DOSES & HOW MANY TIMES YOU TAKE IT:

*Continued on next page*

## NEW PATIENT INTAKE - PAGE 2

DRUG ALLERGIES: *Name of drug(s) and what happens when you take it?*

PHARMACY: *Name of your pharmacy, phone and address:*

HEALTH MAINTENANCE:

When was your last tetanus immunization? _____

When was your last yearly physical? _____

SOCIAL HISTORY:

Occupation:

Do you smoke? ❑ Yes ❑ No ❑ Formerly. If yes, how much?

Do you drink alcohol? ❑ Yes ❑ No ❑ Formerly. If yes, how much & how often?

Are you: ❑ married ❑ single ❑ divorced?

Children & ages:

Hobbies:

Do you exercise? ❑ Yes ❑ No. If yes, what activity & how often?

CHIEF COMPLAINT:

What is the main reason you want to see the physician or provider today?

ONLINE ACCESS TO YOUR LAB RESULTS AND HEALTH RECORDS:

*If you would like to receive your tests results online as well as having secure access to your medical health record online, please provide your email address.*

Email: _____

*Thank you for taking the time to fill out this form!*